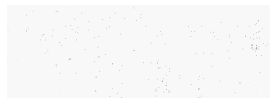


Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF MEDICARE PAYMENTS
MADE TO PACIFICARE OF
CALIFORNIA FOR MEDICAID SPECIAL
STATUS BENEFICIARIES FOR THE
PERIOD JANUARY 1,1995 THROUGH
DECEMBER 31,1998**



**MAY 2001
A-09-00-00103**

Office of Inspector General

OIG Website: www.dhhs.gov/progorg/oig

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region IX
50 United Nations Plaza, Room 171
San Francisco, CA 94102

CIN: A-09-00-00103

May 23, 2001

Debra Logan, Corporate Director
PacifiCare of California
3120 West Lake Center Drive
Santa Ana, California 92799-5186

Dear Ms. Logan:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' report titled "Audit of Medicare Payments Made to PacifiCare of California for Medicaid Special Status Beneficiaries for the Period January 1, 1995 Through December 31, 1998."

Final determinations as to actions taken on all matters reported will be made by the HHS office named below. We request that you respond to that office within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services' reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at <http://www.hhs.gov/progorg/oig>.

To facilitate identification, please refer to Common Identification Number (CIN) A-09-00-00103 in all correspondence relating to this report.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to:

Director, Office of Managed Care
Health Care Financing Administration, HHS
7500 Security Boulevard, Room 33-02-01
Baltimore, Maryland 21244-1850

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

Region IX

**AUDIT OF MEDICARE PAYMENTS
MADE TO PACIFICARE OF
CALIFORNIA FOR MEDICAID SPECIAL
STATUS BENEFICIARIES
FOR THE PERIOD JANUARY 1,1995
THROUGH DECEMBER 31,1998**



**MAY 2001
A-09-00-00103**

THIS REPORT IS AVAILABLE TO THE PUBLIC

at <http://www.hhs.gov/progorg/oig>

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region IX
50 United Nations Plaza, Room 171
San Francisco, CA 94102

CIN: A-09-00-00103

May 23, 2001

Debra Logan, Corporate Director
PacifiCare of California
3120 West Lake Center Drive
Santa Ana, California 92799-5186

Dear Ms. Logan:

This report provides you with the results of our audit of Medicare payments made to PacifiCare of California (PacifiCare) for beneficiaries classified as Medicaid special status during the period January 1, 1995 through December 31, 1998.

Medicare makes enhanced payments to a health maintenance organization (HMO) for all beneficiaries who are enrolled in both Medicare and Medicaid; referred to as Medicaid special status beneficiaries. States may pay the Part B premium (buy-in to Medicare) for its Medicaid beneficiaries who are Medicare eligible. We identified and reviewed 6,657 enhanced Medicare payments made to PacifiCare for 380 Medicaid special status beneficiaries who the State did not buy-in to Medicare during the audit period. These payments totaled \$5,178,167. We examined the Medicaid eligibility of each of the 380 beneficiaries identified. We found that the payments included Medicare overpayments of \$1,438,782 for members who were incorrectly classified as Medicaid special status Medicare beneficiaries.

The Health Care Financing Administration (HCFA) has an administrative policy limiting adjustments on HMO payments to 3 years preceding the month in which notification was made of the need for an adjustment. Therefore, we are limiting our recommendation for payment adjustments to the period that falls within HCFA's policy limits. We notified PacifiCare in the November 2000 draft report of the need for adjustments. Under HCFA's policy, adjustments can be made for 2,444 overpayments made during the period of October 1997 through December 1998. The adjustment for this period totals \$720,858.

We recommend that PacifiCare coordinate with HCFA to refund \$720,858 for the overpayments, identify and process adjustments for inappropriate Medicaid special status payments subsequent to our audit period, and ensure the removal of incorrect indicators for Medicaid special status beneficiaries from HCFA's payment system. PacifiCare did not dispute our audit finding and stated that it relied on HCFA to provide the correct Medicaid status. PacifiCare also indicated that it would cooperate fully with any actions initiated by HCFA to meet our recommendations. PacifiCare's response is included in its entirety in the APPENDIX to this report.

INTRODUCTION

BACKGROUND

PacifiCare is an HMO which is part of PacifiCare Health Systems, Inc.; a health care services company that provides managed care for employer groups and Medicare beneficiaries in nine states and Guam serving over 3.5 million members (972,800 Medicare members). Approximately 2.2 million members are served in California with almost 600,000 of those being Medicare members.

An HMO is a legal entity that provides or arranges health services for its enrollees. Under the Medicare program, HMOs contract with HCFA to provide health care services to beneficiaries. If a Medicare beneficiary enrolls with a contracting HMO, Medicare makes advance monthly payments to the HMO for that beneficiary. The payments are adjusted by a set of risk factors such as age and gender. The rate is then increased for certain categories of beneficiaries. The Medicare beneficiaries who are also eligible for Medicaid are one of these categories and are referred to as Medicaid special status beneficiaries.

Beneficiaries who are eligible for both Medicare and Medicaid benefits may have their Medicare premiums paid by the State under a State buy-in agreement. The buy-in agreement gives the State the option of paying the Medicare Part B premium for any class of Medicaid-eligible recipients it chooses. Payment of the Part B premium by the State is recorded in the HCFA Third Party Master File (TPMF) which is used to update the Enrollment Database with information on the status of beneficiaries eligible for both Medicare and Medicaid.

The HCFA's Group Health Plan (GHP) file contains identifying data and enrollment information, including a Medicaid indicator, on beneficiaries enrolled in and receiving Medicare covered services from group health plans. The GHP is updated from the Enrollment Database to reflect any new information.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government auditing standards. The objective was to determine if enhanced Medicare payments made to PacifiCare were appropriate for beneficiaries classified as Medicaid special status.

Our review of internal controls at PacifiCare was limited to evaluating controls and procedures related to the enrollment of new members. We did not evaluate the adequacy of the internal controls in HCFA's data systems.

As part of our review, we:

constructed a database of all enhanced Medicare payments made to PacifiCare for Medicaid special status beneficiaries for whom the State did not buy-in to Medicare Part B for the period January 1, 1995 through December 31, 1998;

requested Medicaid eligibility verification from the California Department of Health Services' Eligibility Branch (Eligibility Branch) for each beneficiary for each month for which a payment was made;

eliminated from our database all payments made for beneficiaries who were eligible for Medicaid according to the Eligibility Branch during the month for which the payment was made;

reviewed PacifiCare's enrollment records of each beneficiary that was not eligible for Medicaid according to the Eligibility Branch for one or more months for which a payment was made; and

calculated the overpayment.

Our audit was conducted from April through November 2000 with field work performed at our agency's Health Care Financing Audits Division in Baltimore, Maryland; PacifiCare's offices in Cypress, California; and at the Eligibility Branch in Sacramento, California.

FINDING AND RECOMMENDATIONS

We found that the Medicare program overpaid PacifiCare \$1,438,782 for PacifiCare members who were incorrectly classified as Medicaid special status Medicare beneficiaries during the period January 1, 1995 through December 31, 1998.

MEDICAID SPECIAL STATUS

There are two ways to have a beneficiary placed on the GHP data base as having Medicaid special status:

The first method of establishing Medicaid status occurs automatically when a State Medicaid program pays (buys-in) the Part B Medicare premium of a Medicaid recipient who is also eligible for Medicare. The TPMF records this transaction.

The second method of establishing Medicaid special status occurs when an HMO notifies HCFA that it has enrolled a Medicare beneficiary who is also eligible for Medicaid. The HCFA then adds the beneficiary to the GHP data base.

The Medicaid special status of beneficiaries whose eligibility is established under the second method will not change unless the HMO notifies HCFA that the beneficiary is ineligible. Because of this, the GHP data base may include beneficiaries whose Medicaid status was determined under the second method.

SPECIAL STATUS POPULATION

During the period of our review, PacifiCare had approximately 28,000 beneficiaries classified as Medicaid special status. This population includes those beneficiaries enrolled in Foundation Health Plan (FHP) which was acquired by PacifiCare in 1997. We identified from this population 380 beneficiaries for whom the State did not buy-in to Medicare Part B. We reviewed the Medicaid eligibility for the 380 beneficiaries for whom PacifiCare received 6,657 enhanced monthly Medicare payments.

Our audit disclosed 77 percent (5,167) of those payments were made for beneficiaries who were incorrectly classified as Medicaid special status for the month of the payment. We determined that, as a result of the beneficiaries being incorrectly classified as Medicaid special status, PacifiCare was overpaid a total of \$1,438,782 during the audit period.

PAYMENT ERRORS

The following are examples of the types of errors disclosed by our audit.

For one beneficiary, 36 payments were made to PacifiCare during our audit period. However, according to the State Medicaid Eligibility Branch, the beneficiary was not eligible for Medicaid during any of the 36 months. The total overpayment for this beneficiary was \$7,807.

Another beneficiary was eligible for Medicaid for only a portion of the period during which payments were made. In this case, 36 payments were also made. However, the State Medicaid Eligibility Branch indicated that the beneficiary was not eligible during the first 10 months, resulting in overpayments of \$2,661.

In a third case, payments were made for January through June and October through December 1996. The beneficiary was not eligible in March, June and December, resulting in three overpayments totaling \$689.

In all cases, the errors identified were payments made to PacifiCare on behalf of beneficiaries who were not eligible for Medicaid. We discussed the eligibility problem with PacifiCare in an effort to determine how the beneficiaries became incorrectly classified and who was responsible for ensuring the correct classification of the beneficiaries. We reviewed PacifiCare's enrollment process for Medicare beneficiaries to see what impact it had on the classification of beneficiaries as Medicaid special status. We found no evidence that PacifiCare had taken any action to initiate Medicaid special status for beneficiaries during our audit period. PacifiCare officials informed us that they relied entirely upon HCFA to inform them when one of their enrollees became classified as Medicaid special status.

HCFA POLICY ON ADJUSTMENTS

HCFA has an administrative policy limiting adjustments on HMO payments to 3 years preceding the month in which notification was made of the need for an adjustment. Therefore, although we are reporting the full amount of the overpayment made during the audit period, we are limiting our recommendation for payment adjustments to the period that falls within HCFA's policy limits. We notified PacifiCare in the November 2000 draft report of the need for adjustments. PacifiCare did not dispute our finding. We consider this constructive notification of HCFA that adjustments were needed. Under HCFA's policy, adjustments can be made for 2,444 overpayments made during the period of October 1997 through December 1998. The adjustment for this period totals \$720,858.

RECOMMENDATIONS

We recommend that PacifiCare coordinate with HCFA to:

Refund \$720,858 for the 2,444 overpayments identified;

2. Identify and process adjustments for inappropriate Medicaid special status payments subsequent to our audit period; and
3. Ensure the removal of incorrect indicators for Medicaid special status beneficiaries from HCFA's payment system.

PACIFICARE'S COMMENTS

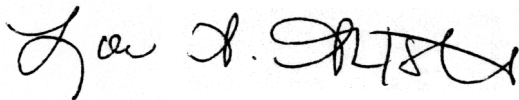
In response to our draft report, PacifiCare did not dispute the audit finding. PacifiCare stated that it relied on HCFA to provide the correct Medicaid status. PacifiCare also indicated that it would

cooperate fully with any actions initiated by HCFA to meet our recommendations. PacifiCare's response has been included in its entirety in the APPENDIX to this report.

* * * *

Final determinations as to actions taken on all matters reported will be made by the HHS office named below. We request that you respond to that office within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand". The signature is fluid and cursive, with the last name being particularly stylized.

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Direct Reply to:

Director, Office of Managed Care
Health Care Financing Administration, HHS
7500 Security Boulevard, Room 33-02-01
Baltimore, Maryland 21244-1850

APPENDIX

PacifiCare®

Health Systems

January 5, 2001

3120 Lake Center Drive
Santa Ana, California 92704-6917
Tel (714) 825-5200Lawrence Frelot
Regional Inspector General for Audit Services
Region IX Office of Inspector General
Department of Health and Human Service
50 United Nations Plaza, Rm. 171
San Francisco, CA 94102-4912

RE: CIN-A-09-00-00103 "Audit of Medicare Payments Made to PacifiCare of California for Medicaid Special Status Beneficiaries for the Period January 1, 1995 through December 31, 1998"

Dear Mr. Frelot:

This is in response to the November 20, 2000 request from the Office of Inspector General for the Department of Health and Human Services (the OIG) to provide comments on the Draft Audit Report on Medicare Payments Made to PacifiCare of California for Medicaid Special Status Beneficiaries for the Period January 1, 1995 through December 20, 1998, (CIN-A-09-00-00103) (the "Draft Report").

The auditors reviewed Medicaid eligibility for 380 beneficiaries for whom PacifiCare of California ("PacifiCare") received enhanced monthly payments for the period January 1, 1995 through December 1998, and identified an overpayment totaling \$ 1,438,782 for members who were incorrectly classified as Medicaid special status Medicare beneficiaries.

The Draft Report identifies three recommendations for addressing the overpayment. The OIG's recommendations are restated below along with PacifiCare's responses:

- 1 *We recommend that PacifiCare coordinate with HCFA to process adjustment totaling \$1,438,782 for the 5, 167 overpayments.*

Response: PacifiCare does not dispute the audit findings regarding the overpayment. However, PacifiCare notes that the Health Care Financing Administration (HCFA) will have to make the payment adjustments to offset/recover the overpayments from monies due PacifiCare. PacifiCare will cooperate fully with HCFA to facilitate payment adjustments in accordance with the terms of its contract.

- 2 *We recommend that PacifiCare coordinate with HCFA to identify and process adjustments for inappropriate Medicare special status payments subsequent to the audit period.*

January 5, 2001 Letter to Mr. Lawrence Frelot

Response: PacifiCare, as a Medicare+Choice (M+C) organization, relies upon HCFA to provide Medicaid eligibility status for enrolled Medicare beneficiaries. PacifiCare has no way to identify which Medicare beneficiaries have been incorrectly reported by HCFA subsequent to the audit period. Once HCFA provides the corrected status, PacifiCare will update its systems.

3. *We recommend that PacifiCare coordinate with HCFA to ensure the removal of incorrect indicators for Medicaid special status beneficiaries from HCFA's payment system.*

Response: As noted above and as noted in the Draft Report, PacifiCare relies upon HCFA to provide and update Medicaid status changes. By way of background, State Agencies report Medicaid eligibility to HCFA through the State "buy-in" program. Payment of the Part B premium by State Agencies is recorded in the HCFA Third Party Master File. The HCFA Group Health Plan (GHP) file contains identifying data and enrollment information, including a Medicaid indicator, on beneficiaries enrolled in and receiving Medicare covered services from M+C organizations. The GHP is updated monthly from the Third Party Master File to reflect any new information. Through the monthly update process, HCFA passes Medicaid eligibility to the M+C organizations and payment is made at the Medicaid rate cell. At this time, due to limitation of the GHP system, PacifiCare has no viable way to coordinate with HCFA to remove incorrect indicators for Medicaid special status beneficiaries from HCFA's payment system. HCFA has advised M+C organizations that the Medicaid status indicator in the GHP system is updated regularly, which should reduce inappropriate payments.

PacifiCare would like to thank the OIG for granting an extension to respond to the Draft Report. If you should have any questions regarding the above, please do not hesitate to contact the undersigned at (714) 825-5464.

Sincerely,



for

Debra Logan
Corporate Director
Membership Accounting Services